24 **Eyre SL**, Hoffman V, Millstein SG. The gamesmanship of sex: A model based on African American adolescent accounts. *Medical Anthropology Quarterly* 1998;**12**:1–23.
25 **Rosengard C**, Adler NE, Gurvey JE, *et al*. Protective role of health values in adolescents' future intentions to use condoms. *J Adolesc Health* 2001;**29**:200–7.
26 **Costa F**, Jessor R, Donovan EJ. Value on health and adolescent conventionality: a construct validation of a new measure in problem-behavior theory. *J Appl Soc Psychol* 1989;**19**:841–61.
27 **Ellen JM**, Cahn S, Eyre SL, *et al*. Types of adolescent sexual relationships and associated perceptions about condom use. *J Adolesc Health* 1996;**18**:417–21.
28 **MacCallum R**, Zhang S, Preacher KJ, *et al*. On the practice of dichotomization of quantitative variables. *Psychol Methods* 2002;**7**:19–40.
29 **Cate RM**, Long E, Angera JJ, *et al*. Sexual intercourse and relationship development. *Family Relations* 1993;**42**:158–64.
30 **Kelly JA**, Kalichman SC. Increased attention to human sexuality can improve HIV-AIDS prevention efforts: key research issues and directions. *J Consulting Clin Psychol* 1995;**63**:907–18.
31 **Lewis JE**, Malow MR, Ireland JS. HIV/AIDS risk in heterosexual college students a review of a decade of literature. *J Am College Health* 1997;**45**:147–57.
32 **Feeney JA**, Ryan SM. Attachment style, assertive communication, and safer-sex behavior. *J Appl Soc Psychol* 1999;**29**:1964–83.
33 **Buysse A**. Oost Van. 'Appropriate' male and female safer sexual behavior in heterosexual relationships. *AIDS Care* 1997;**9**:549–61.
34 **Tschann JM**, Adler NE, Millstein SG, *et al*. Relative power between sexual partners and condom use among adolescents. *J Adolesc Health* 2002;**31**:17–25.
35 **Cooper ML**, Shapiro MC, Powers AM. Motivations for sex and risky sexual behavior among adolescents and young adults: a functional perspective. *J Personality Soc Psychol* 1998;**75**:1528–58.
36 **Regan PC**, Dreyer SC. Lust? love? status? young adults' motives for engaging in casual sex. *J Psychol Human Sexuality* 1999;**11**:1–25.
37 **Taris TW**, Semin GR. Gender as a moderator of the effects of the love motive and relational context on sexual experience. *Arch Sex Behav* 1997;**26**:159–80.
38 **Schwarz N**. Self-reports: how the questions shape the answers. *Am Psychol* 1999;**54**:93–105.

ECHO

Ethicist says doctors are right to help couples with HIV have children

Please visit the *Sexually Transmitted Infections* website [www.stijournal.com] for a link to the full text of this article.

Infertility specialists have the right to help couples with HIV have children, according to one ethical view. They, like all doctors, must ''do no harm,'' but ethical arguments exonerate them if the children are infected.

HIV infection in babies is a serious issue: most rapidly progress to AIDS and death or long term illness and poor quality of life until death in adolescence. So do the specialists' actions constitute recklessness—conscious and unjustified risk taking?

The risk of HIV infection from an infected man to his female partner and children is negligible if assisted conception includes precautions like sperm washing whereas for an infected woman the risk of vertical transmission of HIV to the child is 1–2%. The risk of disease or disability with assisted conception in uninfected infertile couples is thought to be 3–5%, similar to that in the general population. Infertility specialists are not blamed for such outcomes, so they cannot be deemed reckless if the offspring are affected in HIV positive couples.

Fertility specialists' input in assisted conception differs in fertile and infertile HIV positive couples. They are fulfilling their duty of care with fertile couples by cutting the risk of infection to the child and unaffected parent. They have a duty to help infertile couples, and their significant input with infertile over fertile HIV positive couples fulfils that moral obligation. They are responsible for any affected child, but there is no question of recklessness as the additional risk is so low.

▲ *Journal of Medical Ethics* 2003;**29**:321–324.

...and others agree to help for HIV discordant couples

Others support helping HIV discordant couples have children with their own eggs and sperm through in vitro techniques—at least couples in which the man is HIV positive and the woman negative. They cite the 300 children already born to such couples with help from assisted reproductive technologies: neither children nor their mothers have become HIV positive.

Risk to offspring is paramount and may include long term effects of zidovudine and other antiviral treatments whose safety is questionable. Zidovudine does have a record of harming fetuses, but denying fertility treatment on this basis alone would be unjust as many women may have diseases requiring treatment throughout pregnancy—like epilepsy—for which there are no safety data. In fact most drugs have never been evaluated in pregnancy. However, zidovudine integrates into the host genome, with possible but unknown implications for the child and scope for heritable germline alterations, which are concerns.

HIV discordant couples are different from couples who are affected by other terminal illnesses or genetic conditions because of the added risks of infecting the woman and the child and the wider potential public health risk to healthcare workers and other patients undergoing fertility treatment.

On balance, though, offering assisted conception to these couples contravenes no ethical principles and seems to do more good than harm. Arguably, denying treatment might raise the potential for harm—from unprotected sex—but situations of particular risk—say of involving a surrogate mother—justify careful scrutiny and maybe denial.

▲ *Journal of Medical Ethics* 2003;**29**:325–329.